

**Statement of the National PACE Association  
Before the House Ways and Means Committee  
Hearing on the Medicare Payment Advisory Commission Report  
June 19, 2012**

The National PACE Association (NPA) is pleased to submit the following statement for the record in response to the Medicare Payment Advisory Commission (MedPAC) report issued June 15, 2012. NPA applauds Congress and the Commission for its efforts to develop common-sense, sustainable policy solutions that ensure the integrity of the Medicare program. Moreover, NPA appreciates MedPAC's interest in and support of Programs of All-inclusive Care for the Elderly (PACE), particularly its recommendations for expanding the program, developing outcome measures, and ensuring that Medicare payment accurately reflects the costs of caring for a high-need, medically complex population.

Our comments focus mostly on MedPAC's recommendation on payment, as changes to the PACE payment methodology must be carefully balanced to protect the viability of the PACE model.

MedPAC's first recommendation is that Congress direct the Secretary to improve the Medicare Advantage risk-adjustment system to more accurately predict risk across all MA enrollees. Using the revised risk-adjustment system, the Commission goes on to suggest that PACE providers be paid based on the MA payment system for setting county benchmarks and quality bonuses.

While NPA understands and appreciates MedPAC's aim to place all Medicare managed care options on a consistent payment platform through the use of the same county benchmarks, we have concerns that this recommendation does not recognize the unique needs of the frail elderly served by the PACE program and does not address inadequacies in the current risk adjustment methodology.

To begin, MedPAC bases its recommendation on an analysis concluding that PACE payments are, on average, 17 percent greater than fee-for-service costs. We are concerned, however, that the commission is not using an appropriate comparison group. Specifically it is not clear that MedPAC compared payments to PACE to Medicare fee-for-service expenditures for a nursing home level of care population.

PACE exclusively serves the frailest subset of Medicare beneficiaries, older adults requiring nursing home level of care. The vast majority of individuals enrolled in PACE have low incomes, significant disabilities and chronic illnesses, and are dependent on others to help them with at least three basic activities of daily living, such as eating, bathing, transferring, toileting and dressing. About half of our program enrollees have some form of dementia. Approximately 90 percent of PACE participants are 65 years of age or older, averaging 81 years of age, 30 percent of whom are age 85 or older. It is unclear whether the Commission's comparison group reflects the significant needs of typical PACE participants -- those at a nursing home level of care living in the community.

We are also concerned that the comparison does not address inadequacies in the current risk adjustment methodology. As noted in Chapter 4, MedPAC states that the CMS-HCC model does not fully account for severity of illness and interaction of multiple illnesses. It goes on to suggest that, “Because of these shortcomings of the CMS–HCC model, there is a potential for MA plans to benefit financially if they have a relatively healthy beneficiary profile or to be disadvantaged if they have a sicker beneficiary profile. This is especially relevant to plans that specialize in managing the care for the sickest beneficiaries, such as special needs plans (SNPs) and plans in the Program of All-Inclusive Care for the Elderly (PACE) because payments may not be adequately adjusted to effectively provide care.”

While the Commission acknowledges the shortcomings in the HCC model, it suggests that the frailty adjustor applied to PACE payments makes up for this difference and that, in the aggregate, “17 percent is a reasonable estimate” by which Medicare payments to PACE exceed spending in FFS. Unfortunately, the Commission offers no data to support this assertion, nor does it offer data that the relative impact of “overpayment” for some participants is sufficient to offset “underpayment” for other participants.

To more fully understand this issue, NPA respectfully requests the opportunity to review MedPAC’s data and analysis to ensure that the true costs of providing care to this frail, high need population have been adequately captured

In closing, NPA greatly appreciates the Commission’s work and its support for the PACE model. We look forward to continuing to work together to expand the PACE model and to ensure that beneficiaries continue to receive the high quality, integrated care provided by PACE organizations.